# DENTAL CLAIM FORM

**PROVIDER SUPPORT:**
**1.954.331.6530, OPTION 4**

Forward Form and Receipts to:
JIPA Network/Claims
PO Box 2788
Kennesaw, GA 30156-9114 USA
fax: 1.770.810.3789
email: claims@jipanetwork.com

(Please Print)

| Group/Plan Name or Number: | Insured's ID Number: |
|---|---|

## PART 1 MUST BE COMPLETED BY INSURED

| Insured's Last Name: First: Middle: | Patient's Birth Date: mm/dd/yyyy | Patient's ID Number: |
|---|---|---|
| Patient's Last Name: First: Middle: | Patient's Gender: ❑ M ❑ F | Patient's Relationship to Insured: |
| Street Address: | Home Phone #: ( ) Email Address: | Cell Phone #: ( ) |
| City/Town: | Parish/State: | ZIP/Postal Code: |

## ASSIGNMENT OF BENEFITS

**AUTHORIZATION TO RELEASE INFORMATION:**
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits. I hereby certify the information provided is true and correct to the best of my knowledge.

X _____ _____
*Patient's Signature* *Date*

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):**
I hereby authorize payment of benefits directly to Providers submitting claims on my behalf. This payment shall not exceed my indebtedness to the Providers and I have agreed to pay, in a current manner, any charges determined to be not covered by the plan benefits.

X _____ _____
*Patient's Signature* *Date*

## PART 2 TO BE COMPLETED BY PROVIDER OF SERVICE

| MISSING TEETH INFORMATION | Permanent | | | | | | | | | | | | | | | | Primary | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Place an **X** on each missing tooth | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J |
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K |

**REPORT OF SERVICES *(OR ATTACH AN ITEMIZED BILL)***

| Service Date: mm/dd/yyyy | Tooth # or Letter | Tooth Surface | Procedure Code | Description of Services Rendered: | Charges: | Currency Type: |
|---|---|---|---|---|---|---|
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|---|---|---|
| Total Charges: | | |
| Amount Paid: | | |
| Balance Due: | | |

Provider Name and Address:

Phone Number: ( ) .

Email Address: _____

Company TIN: ___ _____

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees.

_____ _____
*Provider of Service Signature* *Date*